

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022863

Facility Name: CRESTWOOD TERRACE

Address: 13304 S. CENTRAL CRESTWOOD 60445
Number City Zip Code

County: COOK

Telephone Number: (847) 674-5795 Fax # (847) 674-5794

IDPA ID Number: 36-2883290

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MORRIS ESFORMES	
	(Title)	GENERAL PARTNER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585	Fax # (847) 675-5777
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number CRESTWOOD TERRACE

0022863 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	46,116	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	46,116	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,140	2,590	2,774	43,504	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,140	2,590	2,774	43,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.34%

D. How many bed-hold days during this year were paid by Public Aid? 253 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **CRESTWOOD TERRACE** # **0022863** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	121,093	13,743	5,940	140,776		140,776		140,776			1
2	Food Purchase		169,522		169,522		169,522	(886)	168,636			2
3	Housekeeping	120,694	17,501		138,195		138,195		138,195			3
4	Laundry	45,374	16,877		62,251		62,251	120	62,371			4
5	Heat and Other Utilities			76,100	76,100		76,100	313	76,413			5
6	Maintenance	1,402	19,953	20,799	42,154		42,154	8,267	50,421			6
7	Other (specify):*			4,695	4,695		4,695	54	4,749			7
8	TOTAL General Services	288,563	237,596	107,534	633,693		633,693	7,868	641,561			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	1,057,430	53,726	21,134	1,132,290		1,132,290		1,132,290			10
10a	Therapy	39,371		3,698	43,069		43,069		43,069			10a
11	Activities	95,591	6,400	1,671	103,662		103,662		103,662			11
12	Social Services	47,834		3,929	51,763		51,763		51,763			12
13	Nurse Aide Training											13
14	Program Transportation			570	570		570		570			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,240,226	60,126	36,402	1,336,754		1,336,754		1,336,754			16
	C. General Administration											
17	Administrative	64,008		155,500	219,508		219,508	(139,695)	79,813			17
18	Directors Fees											18
19	Professional Services			33,873	33,873		33,873	4,688	38,561			19
20	Dues, Fees, Subscriptions & Promotions			15,719	15,719		15,719	(6,448)	9,271			20
21	Clerical & General Office Expenses	93,644	12,846	109,025	215,515		215,515	(71,882)	143,633			21
22	Employee Benefits & Payroll Taxes			215,808	215,808		215,808		215,808			22
23	Inservice Training & Education			725	725		725	49	774			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,593	10,593		10,593	488	11,081			25
26	Insurance-Prop.Liab.Malpractice			58,060	58,060		58,060	387	58,447			26
27	Other (specify):*							3,753	3,753			27
28	TOTAL General Administration	157,652	12,846	599,303	769,801		769,801	(208,660)	561,141			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,686,441	310,568	743,239	2,740,248		2,740,248	(200,792)	2,539,456			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE		0
			0
			5,940
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		34,470
	ELECTRICITY		29,784
	WATER		11,099
	CABLE TV - LOBBY		747
			0
			76,100
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,478
	PAINTING & DECORATING		176
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		9,390
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,271
	FIRE SERVICE		4,484
			0
			0
			0
			20,799
7	OTHER		
	SCAVENGER		4,343
	SECURITY SERVICE		352
			4,695
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,400
			5,400

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	11,170
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	6,364
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	500
	DENTAL		3,100
			0
			21,134
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,259
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,439
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			3,698
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,671
			0
			1,671
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,929
	SOCIAL WORKER	XVIII B 45-2	0
			0
			3,929
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	570	570
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 155,500	155,500
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 12,199	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 21,674	
		0	33,873
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 908	
	EMPLOYEE WANT ADS	XIX F 1,633	
	CONTRIBUTIONS	VI 20 XIX F 500	
	DUES & SUBSCRIPTIONS	XIX F 4,454	
	LICENSES & PERMITS	XIX F 2,501	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 2,471	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 3,052	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	15,719
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	66,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18 14,417	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	365	
	TELEPHONE	14,478	
	MESSENGER SERVICE	0	
	STAFF DEVELOPMENT	13,765	109,025

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 128,320	
	UNEMPLOYMENT COMPENSATION	XIX D 20,351	
	WORKERS COMPENSATION INSURANCE	XIX D 47,079	
	HOSPITALIZATION INSURANCE	XIX D 12,038	
	EMPLOYEE BENEFITS - OTHER	XIX D 300	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 7,720	
	CHICAGO HEAD TAX	XIX D 0	215,808
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	725	725
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	10,593	10,593
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	58,060	58,060
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER 743,239

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,361	57,361		57,361	(16,203)	41,158			30
31	Amortization of Pre-Op. & Org.			696	696		696		696			31
32	Interest			128,641	128,641		128,641	(64,216)	64,425			32
33	Real Estate Taxes			198,841	198,841		198,841	1,343	200,184			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,079	26,079		26,079	3,504	29,583			35
36	Other (specify):* OFFICE RENT			9,828	9,828		9,828	(9,828)				36
37	TOTAL Ownership			421,446	421,446		421,446	(85,400)	336,046			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,174	69,174		69,174		69,174			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			69,174	69,174		69,174		69,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,686,441	310,568	1,233,859	3,230,868		3,230,868	(286,192)	2,944,676			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,340)	30		9
10	Interest and Other Investment Income	(65,463)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(886)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(14,417)	21		18
19	Entertainment		20		19
20	Contributions	(3,552)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(908)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,471)	20		28
29	Other-Attach Schedule	(7,703)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,940)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(173,252)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (173,252)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (286,192)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 6062	6	1
2	STAFF DEVELOPMENT	(13,765)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,703)		49

Summary A

12/31/2004

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	\$ 153,500	EMI ENTERPRISES		\$	\$ (153,500)	1
2	V								2
3	V	17	OFFICERS SALARY				9,132	9,132	3
4	V	19	ACCOUNTING FEES				110	110	4
5	V	21	OFFICE EXPENSE				5,326	5,326	5
6	V	25	TRANSPORTATION				153	153	6
7	V	26	INSURANCE						7
8	V	27	EMPLOYEE BENEFITS				734	734	8
9	V	35	AUTO LEASE				444	444	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 153,500			\$ 15,899	\$ * (137,601)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	\$ 66,000	EKS MANAGEMENT		\$	\$ (66,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				120	120	17
18	V	6	PAINTERS SALARIES				1,413	1,413	18
19	V	7	SCAVENGER				21	21	19
20	V	17	CFO SALARY				4,673	4,673	20
21	V	19	PROFESSIONAL FEES				4,528	4,528	21
22	V	20	WANT ADS/BACKGR CKS				683	683	22
23	V	21	OFFICE EXPENSE				16,836	16,836	23
24	V	23	SEMINARS				49	49	24
25	V	24	IN-STATE LODGING/MEALS						25
26	V	25	TRANSPORTATION				335	335	26
27	V	26	INSURANCE				223	223	27
28	V	27	EMPLOYEE BENEFITS				3,019	3,019	28
29	V	30	DEPRECIATION				179	179	29
30	V	35	EQUIPMENT RENT				2,965	2,965	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 66,000			\$ 35,044	\$ * (30,956)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	\$ 9,828	IME REALTY CORP		\$	\$ (9,828)	15
16	V								16
17	V								17
18	V	5	UTILITIES				313	313	18
19	V	6	REPAIR & MAINTENANCE				792	792	19
20	V	7	ALARM SERVICE				33	33	20
21	V	19	PROFESSIONAL FEES				50	50	21
22	V	21	OFFICE EXPENSE				138	138	22
23	V	26	INSURANCE				164	164	23
24	V	30	DEPRECIATION				958	958	24
25	V	32	INTEREST				1,247	1,247	25
26	V	33	RE TAX				1,343	1,343	26
27	V	35	STORAGE FEES				95	95	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 9,828			\$ 5,133	\$ * (4,695)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	\$ 9,132	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	4,673	17-7	2
3	PHILIP ESFORMES							MGMT FEE	2,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,805		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 2/31/2004

(847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	312,263	16	\$ 9,942	\$	9,828	\$ 313	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	312,263	16	25,152		9,828	792	2
3	7	ALARM SERVICE	RENTAL INCOME	312,263	16	1,056		9,828	33	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	312,263	16	1,575		9,828	50	4
5	21	OFFICE EXPENSE	RENTAL INCOME	312,263	16	4,388		9,828	138	5
6	26	INSURANCE	RENTAL INCOME	312,263	16	5,225		9,828	164	6
7	30	DEPRECIATION	RENTAL INCOME	312,263	16	30,446		9,828	958	7
8	32	INTEREST	RENTAL INCOME	312,263	16	39,619		9,828	1,247	8
9	33	RE TAX	RENTAL INCOME	312,263	16	42,669		9,828	1,343	9
10	35	STORAGE FEES	RENTAL INCOME	312,263	16	3,011		9,828	95	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,083	\$		\$ 5,133	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LASALLE BANK		X	MORTGAGE	\$16,219.00	08/01/95	\$ 3,160,000	\$ 2,334,865	07/31/15		\$ 128,078	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	LASALLE BANK		X	LINE OF CREDIT				165,000			563	6	
7												7	
8	RELATED PARTY	X									1,247	8	
9	TOTAL Facility Related				\$16,219.00		\$ 3,160,000	\$ 2,499,865			\$ 129,888	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,160,000	\$ 2,499,865			\$ 129,888	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.				\$	190,6001
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	193,7412
3. Under or (over) accrual (line 2 minus line 1).				\$	3,1413
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	195,7004
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	198,8417
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	132,399	8	
		2000	135,738	9	
		2001	141,599	10	
		2002	188,724	11	
		2003	193,741	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CRESTWOOD TERRACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0022863

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	24-33-307-001-0000	NURSING HOME	\$ 193,741.46	\$ 193,741.46
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 193,741.46	\$ 193,741.46

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,623

B. General Construction Type: Exterior BRICK

Frame

Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1976	\$ 100,000	1
2					2
3	TOTALS			\$ 100,000	3

Facility Name & ID Number CRESTWOOD TERRACE

0022863

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	126		1976	1971	\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5											5
6											6
7											7
8						921		921			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			8083	24,240					24,240	9
10	BUILDING IMPROVEMENTS			1981	954					954	10
11	BUILDING IMPROVEMENTS			1985	1,000	20	15		(20)	1,000	11
12	BUILDING IMPROVEMENTS			1985	1,884		15			1,884	12
13	BUILDING IMPROVEMENTS			1987	6,130	195	15		(195)	6,130	13
14	BUILDING IMPROVEMENTS			1987	750	24	20	38	14	668	14
15	BUILDING IMPROVEMENTS			1988	64,717	2,054	31.5	2,054		34,537	15
16	BUILDING IMPROVEMENTS			1989	2,985	95	31.5	95		1,453	16
17	BUILDING IMPROVEMENTS			1990	10,962	348	31.5	348		5,047	17
18	BUILDING IMPROVEMENTS			1991	14,001	444	31.5	444		5,950	18
19	BUILDING IMPROVEMENTS			1992	26,640	847	31.5	847		10,570	19
20	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,510	20
21	BUILDING IMPROVEMENTS			1993	5,035	129	39	129		1,500	21
22	BUILDING IMPROVEMENTS			1994	5,220	134	39	134		1,357	22
23	ROOFING			1995	550	14	39	14		137	23
24	ALUMINUM POLES			1995	5,700	146	39	146		1,393	24
25	ROOFING			1995	10,605	272	39	272		2,550	25
26	FURNANCE			1995	764	20	39	20		184	26
27	TILES			1996	9,924	254	39	255	1	2,185	27
28	BATHROOM IMPROVEMENTS			1997	1,378	35	39	35		255	28
29	NURSE STATIONS			1998	51,911	1,331	39	1,331		9,264	29
30	ROOFING			1999	6,500	167	39	167		913	30
31	DOORS, SCUPPER DRAINS			2000	4,750	173	27.5	172	(1)	764	31
32	ALARM/SECURITY SYSTEM			2000	27,728	1,008	27.5	1,008		4,491	32
33	COVE BASE/WALLPAPER			2000	9,250	826	20	462	(364)	1,881	33
34	SMOKE DETECTORS			2001	3,571	130	27.5	130		514	34
35	NEW DURO-LAST ROOF			2001	42,450	1,544	27.5	1,544		5,330	35
36	WALLPAPER, BEADBOARD			2001	10,760	391	27.5	391		1,442	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	VINYL FLOORING	2001	\$ 3,000	\$ 109	27.5	\$ 109	\$	\$ 386	37
38	VINYL FLOORING	2002	3,569	130	27.5	130		320	38
39	HEAT/COOL SYSTEM	2002	1,774	64	27.5	64		157	39
40	FIRE SUPPRESSION SYSTEM	2002	1,874	68	27.5	68		167	40
41	STEEL FIRE DOORS	2003	1,077	39	27.5	39		57	41
42	HEAT/COOL SYSTEM	2003	29,936	1,089	27.5	1,089		1,588	42
43	ASPHALT PAVING	2003	20,049	729	27.5	729		1,063	43
44	WOOD FLOORING	2003	30,570	1,112	27.5	1,112		1,622	44
45	SHEET METAL	2003	1,000	36	27.5	36		53	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,680,273	\$ 15,027		\$ 14,462	\$ (565)	\$ 1,366,516	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$144,789	\$14,695	\$24,100	\$9,405	5 - 10	\$194,961	71
72	Current Year Purchases	47,599	28,560	2,380	(26,180)	10	3,518	72
73	Fully Depreciated Assets	467,199						73
74	RELATED PARTY		216	216			416	74
75	TOTALS	\$659,587	\$43,471	\$26,696	\$(16,775)		\$198,895	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	2,439,860
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	58,498
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	41,158
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(17,340)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,565,411

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 18,246 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITY	03 CHEV EXPRESS VAN	\$ 675.85	\$ 7,833	17
18					18
19					19
20					20
21	TOTAL		\$ 675.85	\$ 7,833	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost							
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	0	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 146,917	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	960,137		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,501		6
7	Other Prepaid Expenses	69,763		7
8	Accounts Receivable (owners or related parties)	777,512		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,022,830	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,277,112		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	447,273		15
16	Equipment, at Historical Cost	666,268		16
17	Accumulated Depreciation (book methods)	(1,996,465)		17
18	Deferred Charges	14,961		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,742,149	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,764,979	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 268,695	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	165,000		29
30	Accrued Salaries Payable	58,476		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,604		31
32	Accrued Real Estate Taxes(Sch.IX-B)	195,700		32
33	Accrued Interest Payable	12,265		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 723,740	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,334,865		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,334,865	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,058,605	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 706,374	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,764,979	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$506,553	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$506,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	383,184	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(183,363)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$199,821	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$706,374	24

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,555,021	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,555,021	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	65,463	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,463	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,620,484	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	633,693	31
32	Health Care	1,336,754	32
33	General Administration	769,801	33
	B. Capital Expense		
34	Ownership	421,446	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	69,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,230,868	40
41	Income before Income Taxes (line 30 minus line 40)**	389,616	41
42	Income Taxes	(6,432)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 383,184	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,140	2,180	\$ 54,920	\$ 25.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,562	5,055	104,270	20.63	3
4	Licensed Practical Nurses	13,968	14,557	298,104	20.48	4
5	Nurse Aides & Orderlies	56,745	60,741	517,286	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,501	4,020	39,371	9.79	8
9	Activity Director					9
10	Activity Assistants	10,742	11,465	95,591	8.34	10
11	Social Service Workers	3,904	4,052	47,834	11.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,607	16,559	121,093	7.31	15
16	Dishwashers					16
17	Maintenance Workers	154	154	1,402	9.10	17
18	Housekeepers	16,540	17,799	120,694	6.78	18
19	Laundry	6,886	7,550	45,374	6.01	19
20	Administrator	2,080	2,194	64,008	29.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,612	12,094	93,644	7.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	4,160	4,388	82,850	18.88	33
34	TOTAL (lines 1 - 33)	152,601	162,808	\$ 1,686,441 *	\$ 10.36	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 5,940	1-3	35
36	Medical Director	O	5,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	500	10-3	38
39	Pharmacist Consultant	H	6,364	10-3	39
40	Physical Therapy Consultant	L	2,259	10a-3	40
41	Occupational Therapy Consultant	Y	1,439	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,671	11-3	44
45	Social Service Consultant	E	3,929	12-3	45
46	Other(specify) DENTAL		3,100	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,602		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		11,170	10-3	52
53	TOTAL (lines 50 - 52)		\$ 11,170		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
KATHLEEN STEEL	ADMIN		\$ 64,008	Workers' Compensation Insurance		\$ 47,079	IDPH License Fee		\$		
	ASST ADMIN		0	Unemployment Compensation Insurance		20,351	Advertising: Employee Recruitment		1,633		
				FICA Taxes		128,320	Health Care Worker Background Check		0		
				Employee Health Insurance		12,038	(Indicate # of checks performed)				
				Employee Meals		#REF!	MARKETING/ADV/PROMO		3,379		
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		3,752		
				EMPLOYEE BENEFITS - OTHER		300	LICENSES & PERMITS		2,501		
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS		4,454		
				PENSION/PROFIT SHARING PLANS		7,720	MGMT CO ALLOCATION		683		
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC		(3,752)		
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0		
							Non-allowable advertising		(908)		
				INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising		(2,471)		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 64,008	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)				
(List each licensed administrator separately.)											
B. Administrative - Other											
Description			Amount								
EMI ENTERPRISES			\$ 153,500								
PHILIP ESFORMES INC			2,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 155,500								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**				
			\$			\$	Description		Amount		
							Out-of-State Travel	\$			
							In-State Travel				
									0		
							Seminar Expense				
									0		
							Entertainment Expense	(
SEE SCHEDULE ATTACHED			33,873				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 33,873	TOTAL			TOTAL				
(If total legal fees exceed \$2500 attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATING	2001	\$ 4,398	3	\$ 733	\$ 1,466	\$ 1,466	\$ 733	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	2002	6,906	3		1,151	2,302	2,302	1,151				
3	PAINTING/DECORATING	2003	9,082	3			1,514	3,027	3,027	1,514			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 20,386		\$ 733	\$ 2,617	\$ 5,282	\$ 6,062	\$ 4,178	\$ 1,514	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM \$6,124
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 69,174
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees